

Treatment type depends on the size, location and number of APFs (Table 1). Guzman et al.⁷ proposed a classification system for APFs, taking into account location, causation and size of the APF in order to determine the appropriate treatment, although this should be developed early in order to avoid the risk of development of PH. Both surgical and endovascular occlusion of the fistula can be attempted. Endovascular treatment has thus currently emerged as a minimally invasive reliable treatment option in such individuals.²

APFs often have a good prognosis, due to the minimal effects of a single APF and the effectiveness of current treatments.

In the case at hand, microcoils were used to embolise the fistula. The final outcome has been positive, with the patient being free of ascites.

Conflict of interest

None.

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Marta Hernández*, Irene González, Elba Llop, Cesar Barrios, Rocio Costero, Jose Luis Calleja, Luis Esteban Abreu

Puerta de Hierro University Hospital, IBD Unit, Gastroenterology and Hepatology Department, Calle Manuel de Falla, 1, Madrid, Spain

*Corresponding author.

E-mail address: Marta.hernandez.conde@gmail.com (M. Hernández).

Typical but less frequently recognized findings in laparoscopic adjustable gastric band slippage



Hallazgos típicos pero menos reconocibles en deslizamiento de banda gástrica ajustable laparoscópica

Sr. Director,

A 37-year-old woman with a laparoscopic adjustable gastric band (LAGB) placed 3 years earlier presented with a 1-day history of sudden onset vomiting, food intolerance and abdominal pain. Physical examination revealed epigastric tenderness and laboratory tests had no significant abnormalities. Abdominal X-ray showed a dislodged gastric band with an abnormal angulation and annular appearance (Fig. 1A). Upper gastrointestinal endoscopy revealed an enlarged eroded gastric pouch (Fig. 2A) with food stasis and an angulated constriction in the distal gastric body, easily traversed (Fig. 2B and C). Barium swallow confirmed the gastric band slippage with gastric pouch enlargement and no progression of oral contrast material into the distal stomach (Fig. 1B). The gastric band was surgically removed (Fig. 1C).

LAGB is an effective, safe and widely used bariatric surgery for treatment of morbid obesity.^{1,2} LAGB is positioned 1–2 cm distal to the gastroesophageal junction, creating a gastric pouch approximately 20–30 mL in size.^{3,4}

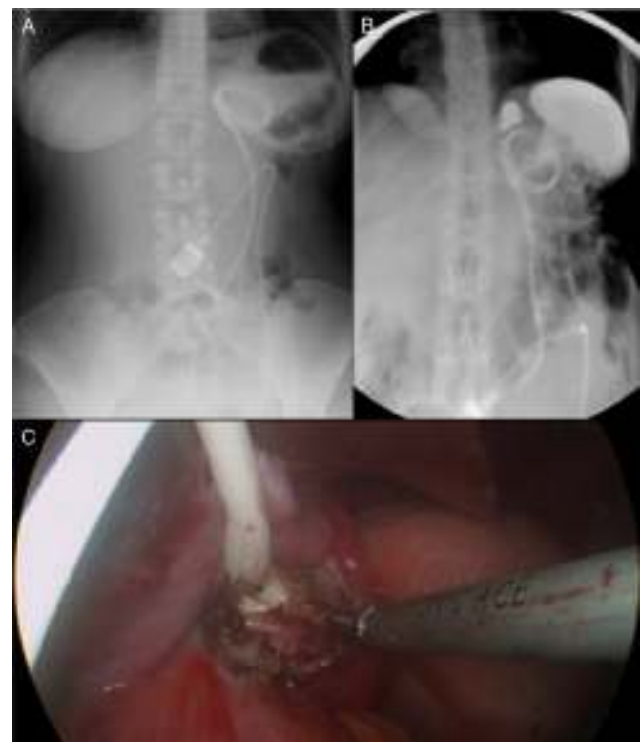


Figure 1 (A) Abdominal radiograph showing an enlarged gastric pouch with an air-fluid level and a dislodged gastric band with an abnormal angulation and annular appearance; (B) barium swallow depicting gastric band slippage with gastric pouch enlargement with retention of oral contrast; (C) laparoscopic image showing removal of the gastric band.



Figure 2 (A) Endoscopic image revealing an enlarged gastric pouch with mucosal erosions; (B) endoscopic image revealing herniation of the distal stomach (arrow) proximal to a narrowed impression (arrowhead) in the distal gastric body secondary to band displacement; (C) endoscopic image after retroflexion of the scope in the antrum, showing an easily traversed angulated constriction in the distal gastric body.

A correctly positioned LAGB has a rectangular shape and an oblique angulation in the left upper quadrant on frontal abdominal X-ray.¹ LAGB slippage is the most commonly reported complication of LAGB placement, affecting 2–4% of patients.^{3,4} LAGB slippage consists of prolapse of the distal stomach upward through the band, leading to eccentric pouch enlargement and constriction with partial or complete obstruction at the level of the band.^{1,2,4} While abdominal X-ray may reveal an air-fluid level in the gastric pouch, gastric obstruction and malposition of the band, endoscopy may depict an enlarged pouch, reflux esophagitis, gastritis, ulcers and necrosis.^{1,4,5} This report outlines the typical findings in gastric band slippage allowing clinicians to recognize similar aspects leading to early recognition of this complication and avoiding a potential deleterious delay in the institution of the appropriate management.

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Ana Ponte^{a,*}, Rolando Pinho^a, Joana Ferreira^b, Carlos Fernandes^a, Iolanda Ribeiro^a, Joana Silva^a, Jorge Carrapita^b, Antónia Póvoa^b, João Carvalho^a

^a Centro Hospitalar Vila Nova de Gaia/ Espinho, Department of Gastroenterology, Rua Conceição Fernandes, 4434-502 Vila Nova de Gaia, Portugal

^b Centro Hospitalar Vila Nova de Gaia/ Espinho, Department of Surgery, Rua Conceição Fernandes, 4434-502 Vila Nova de Gaia, Portugal

* Corresponding author.

E-mail address: ana.ilponte@gmail.com (A. Ponte).